Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2013	2013_189120_0033	H-000124-13	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 16, 2013

During the course of the inspection, the inspector(s) spoke with the general manager, director of care, registered nurse and an identified resident.

During the course of the inspection, the inspector(s) reviewed the identified resident's plan of care and associated documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The resident's right to receive visitors of his or her own choice has not been fully respected or promoted.

An identified resident was interviewed in the home on May 16, 2013 regarding their wishes to be visited by all of their children and grandchildren. The resident was able to answer questions related to their current situation and expressed their desire to be visited by family and friends of their choice. They were able to express concerns about the decisions being made by one of their children, who has Power of Attorney (POA) for personal care and property. The resident was aware that only the POA's family members were allowed to visit and that the POA was prohibiting other family members from visiting. The POA provided written direction to the management of the home that no visitors are permitted to visit or call the resident unless permission was granted by the POA.

The resident's plan of care specified that only certain family members were permitted to visit the resident and that a list was available at the nursing station for staff to review. Interview with registered staff and the general manager confirmed that they are following the written direction from the POA and are in fact ensuring that only the visitor's on the POA's list are able to see or speak with the resident. Management staff confirmed that alternative interventions to facilitate on the resident's behalf to see other family members were not explored.

The resident was described by the registered staff as being capable of making decisions for themselves regarding activities of daily living, that they participated in many group activities and enjoyed active games, trivia and socials. The resident was able to walk independently and only needed physical assistance with dressing and bathing.

Documentation kept by the home for the resident described events that occurred in 2013 that distressed the resident. A family member who was not permitted to visit or speak to the resident tried on numerous occasions to call or visit but was told by home staff that they could not. On a specified date in 2013 the family member tried to visit with the resident but was eventually escorted from the home area and began to cry out. The incident was witnessed by the resident who subsequently also became very upset and cried. The resident expressed to a worker that they felt sad about the "whole situation" that occurred during the day. The resident required support by staff to ease their emotions. [s. 3(1)14.]

Issued on this 22nd day of July, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B. Susnik